

Introduction¹

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Hospitals are at once the site of the clinical encounter, the locus of medical teaching and research, and a cornerstone of health insurance and the welfare state. For medical historians, then, the study of the hospital must be multi-faceted, and in this book our perspective is that of political economy. Our starting point is the transformation undergone by health services during the twentieth century into one of the fastest growing economic sectors. While the level of health expenditures in rich countries was probably about 1% of GDP in 1900, it had risen (according to OECD statistics) to 4-6% in 1970 and to 10% or more by 2015.² Emerging economies have recently followed the trend, with, for example, health expenditures between 1995 and 2014 rising from 4% to 6% of GDP in China and 4% to 5% in India.

Much of these rising costs were consumed by the hospital service, with all its demanding requirements. Some were material and institutional, with heavily capitalised infrastructure, cutting-edge technologies, and highly trained professionals. Some were social and symbolic, in the costs of delivering health security and meeting political promises of access and provision. Hence the hospital's historical importance lay partly in its capacity to promote different economic activities and employment, not just medical care, but also the construction industry and the myriad administrative and ancillary services. And it lay partly in the policy arena, in which the relationship of competition and cooperation between public and private constituted an ongoing focus of political debate.

Despite their importance, and notwithstanding many single-institution histories, there are few historical studies that analyse the growth of hospital systems in major countries, their characteristics and their role within larger health care and welfare states. Lack of sources, complexity, and heterogeneity in their creation may partly explain this relative scarcity. The focus so far has been largely on Europe, with the German³ and French cases⁴ especially noteworthy, while the peculiarities of the British voluntary hospital have been much explored.⁵ Outside Europe there are classic studies from the United States⁶ and more recent contributions on the hospital system in Japan⁷, China⁸ and Sub-Saharan Africa.⁹

Such studies have laid the groundwork for conceptualising emergent hospital systems in ways that transcend national stories. Different forms took precedence depending on time and place, but broadly a mixed economy of health care was initially prevalent, with some combination of charity, state action and private payment. In Western Europe, the Anglosphere and Latin America, there seems to have been a mix of philanthropy and tax funding for public hospitals, and increasingly various types of mutual sickness insurance concerned with income replacement and primary care. Some countries had more comprehensive social health insurance of the type pioneered in Germany from 1883, including hospital cover. In colonial settings, the mixed economy could combine missionary medicine, private facilities for industrial workers, and state hospitals that addressed the needs, or fears, of European populations. For non-Western countries with indigenous medical practices, the growth of the public hospital was also shaped by the encounter with biomedicine, and the decisions taken about how this episteme should be incorporated with existing traditions.

By the mid-twentieth century, these diverse hospital trajectories were transformed into more integrated and regulated systems. Different factors combined to bring this about: the unprecedented levels of wealth now available to finance social costs in the advanced economies; the universalist political doctrines of socialism and liberal democracy; the imperative of

‘development’ that infused West/South relations in the late-colonial and early Independence era; and the broad authority attributed to biomedicine and its technologies over other modes of healing. In the rich countries there was a transition either to tax-based national health services, first piloted in New Zealand from 1938, or to one of two basic models of health insurance, the state social insurance arrangements mostly prevailing in Western Europe, or the private / non-profit approaches that took precedence in the United States.¹⁰ Henceforth, European hospital systems would be heavily determined by the prevailing modes of coverage, the balance of insurance or tax-funding, and the mix of public and private ownership.¹¹ Meanwhile, in the United States, with private insurance much more prominent and commercial interest groups highly influential, the hospital system grew progressively more costly, while remaining less inclusive.¹²

In some poorer nations, development funding began to build hospital provision and to establish local training capacity, though in many places the legacy of colonial geographies meant institutional concentration in urban centres.¹³ Yet while the high-income countries now drove towards universalism and planned hospital systems, in much of the world expansion was elusive. The economic take-off on which self-sustaining social expenditure was premised proved hard to achieve, as relationships of underdevelopment reasserted themselves. Improvement to hospital systems therefore took second place to infectious disease programmes or improving access to selective aspects of primary care.¹⁴

By the end of the twentieth century access to hospitals in most European Union countries was through a universal compulsory health insurance scheme within a broader social protection system. However, private health insurance had become increasingly important, either complementing or supplementing state packages.¹⁵ The context was one of neo-liberal philosophies, waves of privatisations, retrenchment and the ongoing fiscal crisis of welfare states: all have

been bitterly contested in the arena of health politics. Thus, while the foothold of private insurance in the hospital market is common across OECD countries, this varied (2002) from 92% population coverage in the Netherlands (where it was highly regulated), to 13% in Spain and 10% in the UK. In the United States the eventual expansion of health cover under social security, through Medicare and Medicaid for older and poorer populations, had not resolved inequities of hospital access, and recurrent reform efforts were politically inflammatory.¹⁶ In China, the unleashing of private enterprise after Mao's death saw increasing commercialisation of the hospital, and earlier social protection systems undermined, especially for rural populations.¹⁷ The dominance of the World Bank over development policies in low-income countries anxious for debt relief imposed the 'Washington consensus': that purely statist welfare models were dysfunctional and that plural forms hospital provision, financed more extensively from user fees were the way forward.¹⁸ For such places the century closed with fierce debate on whether this 'structural adjustment' had brought negative effects, and with the grail of universal health coverage still far off.

In sum, then, the work of medical and welfare historians has provided a broad chronological and conceptual framework within which to write the history of hospital systems. The aim of this book is to interrogate this framework further, through a series of studies that range over time and space. Specifically, we are interested in the variations between places in the structure and organisation of hospital systems, the balance between public and private sectors, and the politics attending this. These problems break down into subsidiary objectives, which the authors tackle. From a public and private perspective, why and how were medicine, health and hospitals transformed? To what extent were the different national trajectories of the twentieth century determined by earlier configurations of funding and ownership? Why

did a hospital model based on private institutions gain ascendancy in some countries while state-built hospitals took precedence in others? What was the historical relationship between public and private hospitals over time: did they collaborate or compete? To what extent was the development of hospital systems conditioned by economic and political factors?

Analysis of the financing and administration of different hospital systems raises a conceptual challenge. How exactly should hospital scholars seeking a shared language for comparative discussion delineate 'public' and 'private'? Our cases show that 'public' hospitals could have non-statutory income sources, and that 'private' hospitals ranged from commercial to non-profit, with many different shades between. Here we begin with a definition of public hospitals as being the property of the central, regional or local state. We also distinguish between private hospitals created as profit-making companies and those constituted as charitable institutions financed by private foundations. The chapters will bring into view the national variants and consider how far they acted in a complementary or a competitive fashion.

With respect to timeframe, our initial suggestion that authors began their accounts in the late-1800s proved both helpful and misleading. Clearly the hospital underwent 'medicalisation' at some point, transforming it from an institution with limited therapeutic efficacy that sheltered the terminally ill, sustained the poor, and gave spiritual aid, into something else. For some, the later nineteenth century seems the moment that the modern hospital emerged, albeit retaining the tradition of refuge offering bed rest and nursing, but now also a diagnostic centre exploiting observational and laboratory techniques, locus of new therapies, grounded in biomedical sciences, and all staffed by medical professionals and qualified auxiliaries.¹⁹ Others though have found in histories of case selection, of record

keeping, and of the language and gaze of the physician, evidence of much earlier beginnings.²⁰ Alongside these narratives of Western modernity, as we will see, run others from across the globe, which observed their own chronologies. For example, the interplay between a biomedical profession in the making, a hospital sector combining healing, proselytising and social control, and the needs of the state, could shape such factors as the balance of primary or institutional care, or the persistence of charitable status across several centuries.

Today's health care debates and the present economic uncertainties make this a salient moment to consider from a historical perspective the hospital networks constructed by different states. To date we do not have a historical analysis that provides an overall explanation of their geographical development, their capacity of coverage, their singularities in international terms and their main deficiencies. Thus, in general terms, all the chapters include the following aspects: a first part establishing the historical hospital inheritance at least from the late nineteenth and early twentieth centuries, and in some cases significantly earlier; followed by explanation of the different stages of growth in the twentieth century, with emphasis on models, financing, construction and institutional aspects that conditioned pathways of hospital development, on its journey to become a necessary part of the twentieth-century welfare state.

Composition of the book

Our historical case studies begin with Spain and Brazil, to observe hospital models rooted in early modern charitable practices, where politics and pace of economic development forestalled moves to universalism until quite late in the twentieth century.

The Spanish case analysed by Vilar-Rodríguez and Pons-Pons initially bore similarities to other European countries, with limited systems inherited from *Ancien Régime* charity and then perpetuated by liberal governments. This comprised a public hospital sector that combined charity and limited state budgets, as well as institutions linked to municipal and provincial councils, and a private realm of hospitals and asylums run as charitable foundations. Obsolete in terms of fabric and equipment, this only began to change from the 1920s with the emergence of hospitals founded by industrial businesses, friendly societies and insurance companies, as well as clinics and polyclinics created by entrepreneurial doctors for the middle class. Spain's Civil War (1936-9) and subsequent Franco dictatorship (1939-75), meant its path diverged somewhat from Northern Europe, where integrated social security systems meant a move towards universal coverage. While the fascists introduced compulsory sickness insurance (1942) and a Health Care Facilities Plan, which led to the creation of an expensive new system, these moves were not responses to demand or redistributive equity. Instead they served propaganda purposes and compensated the groups and regions that had supported the regime. Meanwhile insufficiency of public beds favoured the private system, which collaborated in the management of the state health insurance. By the late 1960s, pressure from urbanisation and population growth on the fragmented, understaffed and technologically backward hospital network was stalled by lack of funding and political paralysis: Spain did not even have a Ministry of Health until 1977. With the transition to democracy health care coverage became a right under the 1978 Constitution, and in 1986 the country's health care and hospital model was redefined after decades of underinvestment and uneven growth.

Nemi's study of Brazil, a Portuguese colony until 1822, similarly reveals long-term processes shaping the configuration of its hospital system. Despite the creation of a national health service by legislation

in 1988, these survivals make aspects of the Brazilian model more similar to the United States, with private hospitals claiming public funds, tax exemption privileges, and organisational autonomy. This trajectory, Nemi shows, dates to the colonial era when the *misericórdia* organised health care through voluntary donations and enjoyed privileges granted by the Portuguese Crown. These structuring foundations substantially persisted after Brazilian independence in 1822, as the experience of the Hospital of the São Paulo Holy House of Mercy demonstrates. Such institutions, and similar philanthropic hospitals in the later nineteenth century, negotiated tax exemption rates for providing free health care to the poor, combining private charity with public resources from municipal councils. Behind this public/private interplay lay the interest of local elites – initially landowning but increasingly business and medical – to maintain a field of economic and social power that allowed them to shape urban development. Moving into the twentieth century, Nemi takes the teaching hospital of the São Paulo School of Medicine as emblematic. The enduring integration of public and private/philanthropic sectors persisted into the era of social insurance, and beyond to the 1988 Constitution which permitted such hospitals to enter service provision contracts with the public health service. Couched within neoliberal discourse about the inefficiency of the public sector these have remained a vehicle for the persistence of private medicine, the undermining of universalism, and the diversion of public funds and resources to support patients with private health insurance.

Next we move to Germany, where the archetypal form of social health insurance was pioneered, and to Central Europe, where the successor states created after the First World War saw hospital policy as an aspect of nation-building.

Hüntelmann begins by noting the chorus of concern in Germany since the 1960s about the deficiencies of hospital financing, which have inflicted a near-perpetual reign of cost-containment reforms.

Although such debates appear relatively new, they are, he contends, only the latest iteration of a discourse originating in the early nineteenth century when the hospital became 'modern'. After tracing these beginnings, he sets out the impact of Germany's statutory health insurance system from the 1880s, then describes how hospital finance changed over the twentieth century. The interrelationship between health insurance and hospital funding has wrought significant changes in the character of the hospital. Most fundamental were the transition from a charitable to a medical and public institution at the end of the nineteenth century, and that from welfare institution to public enterprise in the last decades of the twentieth. This has shifted the role of the hospital, he argues, from an institution primarily responsible to the community, into a profit-orientated enterprise, in which health has too often been reduced to a cost-factor in debates about ailing public finances.

A narrower chronology is taken by Doyle, Grombir, Hibbard & Szelinger, who explore the creation of hospital systems in interwar Central Europe. Their interest is the new nations which emerged following the collapse amidst revolution and defeat in 1918 of the three multinational empires that had hitherto dominated this region. Concentrating on Poland, Czechoslovakia and a much-truncated Hungary, they show how they sought to utilise health care, and especially hospital provision, as evidence of their progressivism and modernity, and as a symbol of nationhood. Yet their intentions were constrained by a complex health inheritance, persistent financial crises and significant health challenges, especially in their poverty-stricken eastern regions. Blending research in national archives with international perspectives from the League of Nations and the Rockefeller Foundation, they examine the provision and extent of institutional care, how its institutions and patients were financed, and how the multi-ethnic character of these nations impacted on hospital policy and its role in nation building. While each country put considerable effort, resource

and political will into creating national health care systems, financial weakness, ethnic conflict and urban rural divisions limited their choices and curtailed expansion and modernization. This analysis, Doyle, Grombir, Hibbard & Szelinger argue, contrasts revealingly with the rather teleological 'road to the welfare state' narratives which mark Western hospital histories of this same period.

Studies of the Anglophone countries, Britain and the United States then follow, their systems apparently not dissimilar at the end of the nineteenth century, but subsequently diverging dramatically.

The well-researched British case has long been a historiographical reference for the hospital in a system that culminated in the post-war welfare state. Gorsky utilises this familiar framework in a new way, to interrogate the proposition from welfare economics that the market, the state and the voluntary sector each have demonstrable virtues and limitations as providers of social goods. Can the dynamics of 'market failure', 'state failure' and 'voluntary failure' explain changing preferences for modes of hospital provision through time? Taking a long-run view, he addresses four key questions. First how do we explain the pattern of growth of the hospital up to the mid-twentieth century, with its distribution between private, public and voluntary sectors? The private hospital sector seems always to have been small, and through the nineteenth century the state emerged as the dominant provider thanks to its default role in managing populations that fell outside the labour market; the smaller voluntary sector meanwhile circumvented the stigmatising aspects of state provision for the respectable poor, while also serving a social function for donors. Second he examines the major system reform c.1942-48, when the National Health Service brought hospitals under the central state. Voluntary failures and the inequities of local government partly account for this, but explanation also includes the displacement effect of war, the role of the labour movement,

the capacity of the British state, and path dependent processes. Third he accounts for the late twentieth century decline of the hospital, and its changing distribution between public and private sectors. State failure does not adequately explain these changes: deinstitutionalisation of psychiatric care was also driven by changing therapeutic management, while the rise of the private hospital followed deliberate and contingent political decisions. Finally, he appraises the emergence of an active policy of management of the state hospital sector from the 1960s, arguing that evidence for failure lay not with the intrinsic nature of public administration, but with the periodic tendency towards underfunding.

The different path taken across the Atlantic is revealed in Hoffman's discussion of the United States, whose hospital system trajectory was unlike other Western nations. While it has both public and private hospitals, the latter are supported with extensive public subsidies while maintaining an ideology of private control and rejection of 'government interference'. The consequent implications for access to care, public accountability, and patient voice have created what Rosemary Stevens called the 'essential historical dilemma' of American hospital politics. Hoffmann examines this interleaving of public and private, first sketching the blurred distinction between public and private sectors after government subsidies rescued private hospitals during the Great Depression. A massive increase in federal funding of private hospital construction following World War Two, and the establishment of the Medicare and Medicaid programmes in 1965, further increased the scale of taxpayer subsidies to the private hospitals, whose insistence on autonomy from government control was mostly accepted by Congress. This process, Hoffmann shows, created serious obstacles to access, for example through the funding for segregated hospitals in the U.S. South that allocated services based on race. It also contributed to inefficiency, inequity and massive cost inflation, notably through

the Medicare programme, which until the 1980s allowed private hospitals to set their own fees. Yet she also finds examples of citizens utilizing federal programmes to demand greater access to care: the medical civil rights movement's protest at segregated hospitals in the 1960s; Medicaid recipients' law suits against hospitals that refused to accept poor patients in the 1970s; and the establishment of a right to emergency care in 1986. The chapter concludes with the impact of the 2010 Affordable Care Act ('Obamacare') which provides federal subsidies to the private health insurance industry and expands Medicaid coverage for low-income people, bringing hospitals millions of newly insured patients. It thus embodies the same public-private paradox.

The book closes with China, whose case demonstrates the adoption of the biomedical hospital in a great power undergoing rapid modernisation, in conditions of intense political upheaval. Xu and Mills begin by pointing out that although China was once considered an international model for low-cost rural primary health care, this reputation was founded on a short-lived combination of factors. Over the long term, China has instead suffered from chronic concentration of high-quality resources in its hospitals, despite recurrent efforts to strengthen primary care. Their chapter analyses the historical evolution of both hospitals and primary care in China from the perspective of financing, in a study covering the period 1835-2018. It shows that the developmental trajectories for earlier models of hospital and primary care diverged between 1835 and 1949, with low-cost primary care emerging only after the establishment of relatively elitist hospitals. The divergence was consolidated, they argue, between 1949 and 1978, giving rise to two different models with contrasting fiscal space, service-finance methods and administrative policies. After 1978, market-based financing mechanisms brought direct competition for patients and resources between hospitals and primary care providers, and exposed the weakness of the latter. Pharmaceuticals and technologies became critical vehicles for

hospitals' revenue generation. Increasingly, available resources were absorbed primarily by hospitals, while primary care continued to be under-resourced. Overall, the study sheds light on how historical health financing influences in China have shaped contemporary challenges in finding the appropriate balance of care to serve the population.

Together, the chapters enable us to advance the historical world map of the construction of the different hospital models. While our authors do not make specific use of path dependence theory, they do emphasise the impact of diverse institutional frameworks in defining national health systems, and the long-term reach of these influences. Their comparative perspective advances understanding of the complexities involved in each country, and each branch of the hospital system and brings new evidence to the current debate on health care models, financing and health reforms. This book, with the encouragement it gives to comparative and cooperative research, aims to allow us to find better answers to that deceptively simple, and engrossingly complex question: what is the hospital?

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